The Commonwealth of Massachusetts
State Board of Retirement
One Ashburton Place, Boston, MA 02108-1607

Timothy P. Cahill
Treasurer and Receiver General
Chairman

ROOM 1219
(617) 367-7770
1-800-392-6014

RETIREMENT INFORMATION SHEET

APPLICATION PROCESS

If you are actively employed or on a leave of absence you may file your application to retire no earlier than 120 days before you plan to retire. If you file after sixty days after your retirement, your benefits will not be retroactive to your retirement date. If your application is not received at least 15 days prior to your date of retirement, the earliest date your retirement can take effect, by law, is 15 days from the date the Board receives your application.

The State Retirement Board strongly recommends that you plan your retirement and that you file at least 30 to 60 days in advance of leaving your job. Once your effective date of retirement has passed, you cannot change your retirement option nor can you change your date of retirement or "unretire."

When filing your retirement application, please include the following documents:

- Fully completed application.
- Option Selection Form A, B, or C.
- W-4P Federal Tax Withholding form indicating withholding amount for federal income purposes.
- Copy of Birth Certificate.
- Copy of Veteran's Discharge papers (DD 214), if applicable.
- If you are taking Option C, a copy of the beneficiary's birth certificate, and a copy of the marriage license if the beneficiary is the applicant's spouse. If the beneficiary is a former spouse, the spouse must be unmarried as of the date of retirement.

COUNSELING

If you are interested in individual counseling, walk in counseling service is available at the State Board of Retirement office, located at One Ashburton Place, Room 1219, Boston, from 7:45 a.m. to 5:00 p.m., Monday through Friday.

Website: www.state.ma.us/treasury/srb.htm

IMPORTANT NOTICE REGARDING TERMINATION RETIREMENT APPLICATIONS

A termination retirement allowance, under section 10(2)(a) of chapter 32 of the General Laws of Massachusetts, is only available to a member of the State Retirement System with twenty or more years of eligible service who fails to nomination or re-election, or fails of reappointment, or whose office or position is abolished, or who is removed or discharged from his or her office or position without moral turpitude.

Under section 10(2)(a) of chapter 32, any member who is removed or discharged for violation of laws, rules, or regulations applicable to his or her office or position, or any member whose removal or discharge was brought about by collusion or conspiracy, is not entitled to a section 10 termination.

Section 10(2)(a) requires that the employer of any employee applying for a termination retirement allowance to certify in writing, under the pains and penalties of perjury, that one of the following circumstances applies: (1) that the employee has failed of nomination or re-election, (2) that the employee has failed of reappointment, (3) that the employee's office or position has been abolished, or (4) that the employee has been removed or discharged from his or her position without moral turpitude on his or her part. Retirement Board decisions on requests for termination retirement allowances are subject to review by the Public Employee Retirement Administration Commission ("PERAC").

Additionally, under section 9B of chapter 93 of the General Laws of Massachusetts, any member who files a fraudulent application for a section 10 termination retirement allowance, for example, an application brought about by collusion or conspiracy, may be liable for penalty of two thousand dollars, as well as double amount of any section 10 termination allowances received.

STATE BOARD OF RETIREMENT

One Ashburton Place, Room 1219
Boston, MA 02108-1607
Phone: (617) 367-7770 Fax: (617) 723-1438

RETIREMENT APPLICATION

I respectfully request superannuation retirement under the provisions of Section 1 to 28 inclusive of Chapter 32 of the Massachusetts General Laws, with _____years and _____months of service.

SOC. SEC. NO.:_____ I WISH TO RETIRE ON:_____

NAME: _____ALL FORMER NAME(S):_____

PRESENT ADDRESS:_____
Street City State Zip

MARRIED? Yes _____ No_____ SPOUSE'S NAME: _____

SPOUSE'S ADDRESS, IF DIFFERENT:_____
Street City State Zip

ADDRESS AFTER RETIREMENT: _____
Street City State Zip

HOME PHONE: (____)_____ WORK PHONE: (____)_____

DATE OF BIRTH: (COPY OF BIRTH CERTIFICATE REQUIRED):_____

GENDER: MALE _____ FEMALE_____ VETERAN (COPY OF DD 214 REQUIRED): Yes _____ No_____

MY LAST STATE AGENCY WAS :_____ POSITION:_____

RETIREMENT GROUP, IF KNOWN: Group 1 _____ Group 2 _____ Group 3 _____ Group 4 _____

HAVE YOU EVER BEEN CHARGED OR CONVICTED OF AN OFFENSE INVOLVING THE FUNDS OR PROPERTY OF YOUR PLACE OF EMPLOYMENT? Yes _____ No _____

IF YES, PLEASE DESCRIBE THE OFFENSE:
_____

_____

HAVE YOU EVER BEEN CONVICTED OF AN OFFENSE INVOLVING YOUR POSITION WHILE IN STATE SERVICE? Yes _____ No _____

IF YES, PLEASE DESCRIBE THE OFFENSE:
_____

_____

HAVE YOU EVER TAKEN A REFUND? Yes ___No ___ IF YES, DO YOU WISH TO BUY BACK TIME? Yes ___ No ___

HAVE YOU EVER BEEN ON INDUSTRIAL ACCIDENT LEAVE? Yes ____ No_____ IF YES, WHAT YEAR (S)? _____

IF YOU ARE APPLYING FOR RETIREMENT UNDER THE PROVISIONS OF SECTION 10 OF CHAPTER 32, BY REASON OF RESIGNATION, FAILURE OF RE-ELECTION OR RE-APPOINTMENT, REMOVAL, OR DISCHARGE, WRITE A BRIEF SUMMARY OF THE FACTS OF YOUR SEPARATION ON THE REVERSE SIDE OF THIS FORM.

LIST ALL SERVICE WITH STATE, CITY, TOWN OR COUNTY GOVERNMENT.

DEPARTMENT OR SUBDIVISION	START DATE	DATE SERVICE ENDED

THE ABOVE IS A TRUE STATEMENT MADE UNDER THE PENALTIES OF PERJURY. I UNDERSTAND THAT THERE ARE THREE (3) OPTIONS A, B, OR C AND THAT IF I DO NOT PROVIDE A PROPERLY COMPLETED OPTION SELECTION FORM, I WILL BE AWARDED OPTION B.

_____ _____

SIGNATURE DATE

OPTION DEFINITION

OPTION A: Provides for the largest possible allowance under retirement law. I understand that by choosing this option that my beneficiary (ies) relinquish all claims to total deductions with interest that may be credited to my account upon my death.

OPTION B: I understand that by choosing this option that I will receive a reduced retirement allowance for life. I also understand that upon my death any remaining balance in my account (deposits and interest) at retirement will be refunded to my beneficiary (ies) or estate.

OPTION C: I understand that by choosing this option that I will receive a reduced retirement allowance for life. I also understand that my named beneficiary will receive two-thirds (2/3) of my retirement allowance upon my death for his/her lifetime. I also understand that should the named beneficiary pre-decease me, my allowance will revert to option A.

OPTION SELECTION CANNOT BE CHANGED AFTER RETIREMENT DATE

IF A W-4P FEDERAL INCOME TAX WITHHOLDING STATEMENT IS NOT FILED, FEDERAL INCOME TAX WITHHOLDING WILL BE CALCULATED AS IF THE RETIREE IS MARRIED WITH THREE (3) EXEMPTIONS.

A RETIREE MAY RETAIN HEALTH INSURANCE AND LIFE INSURANCE AFTER RETIREMENT. CONTACT YOUR PAYROLL DEPARTMENT FOR FURTHER INFORMATION.

ADDITIONAL SERVICE

DEPARTMENT OR SUBDIVISION	START DATE	DATE SERVICE ENDED

COMMENTS:

The Commonwealth of Massachusetts
State Board of Retirement
One Ashburton Place, Boston, MA 02108-1607

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OPTION SELECTION FORM

OPTION A
THERE ARE NO SURVIVOR RETIREMENT BENEFITS.

I request my pension be paid in accordance with Option A as provided in Section 12, subsection 2 of Chapter 32.

I UNDERSTAND BY CHOOSING THIS OPTION, UPON MY DEATH, I RELINQUISH ALL CLAIMS TO THE TOTAL CONTRIBUTIONS AND THE TOTAL INTEREST THAT HAVE BEEN CREDITED TO MY ACCOUNT. My Designated Beneficiary(ies) listed below will receive only a prorated amount for the number of days I live in the month of my death.
PLEASE INDICATE BELOW YOUR DESIGINATED PRIMARY BENEFICIARY(IES)

PRIMARY BENEFICIARY INFORMATION (MUST BE COMPLETED)

PROPORTION

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS:_____

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS:_____

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS:_____

TO ADD MORE PRIMARY BENEFICIARIES OR TO ADD CONTINGENT BENEFICIARY(IES), USE REVERSE SIDE

MEMBER INFORMATION

PRINT NAME:_____ SSN#._____

SIGNATURE:_____ DATE:_____

SIGNATURE OF WITNESS- THIS OPTION FORM MUST BE WITNESSED. IF THE MEMBER IS MARRIED, THE WITNESS MUST BE THE SPOUSE. IF NOT MARRIED, ANYONE CAN WITNESS FORM.

By witnessing this form, I acknowledge that I have read and understand the provisions of this Option:

PRINT NAME:_____

ADDRESS:_____

SIGNATURE:_____ DATE:_____

INDICATE BELOW ANY ADDITONAL BENEFICIARY (IES) AND/OR CONTINGENT BENEFICIARY (IES)

PROPORTION

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS:_____

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS:_____

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS:_____

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OPTION SELECTION FORM

OPTION B

LUMP SUM PAYMENT TO BENEFICIARY IN EVENT OF EARLY DEATH

I request my pension be paid in accordance with Option B as provided in Section 12, subsection 2 of Chapter 32.

I UNDERSTAND BY CHOOSING THIS OPTION, I WILL RECEIVE A REDUCED MONTHLY RETIREMENT ALLOWANCE FOR LIFE. I ALSO UNDERSTAND THAT UPON MY DEATH, IF THERE IS A REMAINING BALANCE IN MY ACCOUNT - DEPOSITS AND INTEREST – IT WILL BE REFUNDED TO MY BENEFICIARY (IES) OR ESTATE IN A LUMP SUM. THE DESIGNATED BENEFICIARY (IES) WILL RECEIVE A PRORATED AMOUNT FOR THE NUMBER OF DAYS I LIVE IN THE MONTH OF MY DEATH. I UNDERSTAND THAT THE ANNUITY PORTION OF MY ALLOWANCE IS REDUCED EACH MONTH. IF MY ANNUITY SAVINGS ACCOUNT IS DEPLETED AT TIME OF MY DEATH, I UNDERSTAND THAT THERE WILL BE NO SURVIVOR BENEFIT.

PLEASE INDICATE BELOW YOUR DESIGNATED BENEFICIARY (IES):

PRIMARY BENEFICIARY INFORMATION (MUST BE COMPLETED)

PROPORTION:

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS: _____

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS: _____

TO ADD MORE BENEFICIARIES AND CONTINGENT BENEFICIARY (IES) USE REVERSE SIDE OF THIS FORM.

MEMBER INFORMATION

PRINT NAME:_____ SSN#:_____

SIGNATURE:_____DATE:_____

SIGNATURE OF WITNESS- THIS OPTION FORM MUST BE WITNESSED. IF THE MEMBER IS MARRIED, THE WITNESS MUST BE THE SPOUSE. IF NOT MARRIED, ANYONE CAN WITNESS FORM.

By witnessing this form, I acknowledge that I have read and understand the provisions of this Option:

PRINT NAME:_____

ADDRESS:_____

SIGNATURE:_____DATE:_____

INDICATE BELOW ANY ADDITIONAL BENEFICIARY (IES) AND/OR CONTINGENT BENEFICIARY (IES)

PROPORTION

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS: _____

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS:_____

NAME:_____ SSN#_____ D.O.B.___/___/___ _____%

ADDRESS: _____

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OPTION SELECTION FORM

OPTION C
JOINT SURVIVOR ALLOWANCE

I request my pension be paid in accordance with Option C as provided in Section 12, subsection 2 of Chapter 32.

I UNDERSTAND BY CHOOSING THIS OPTION, I WILL RECEIVE A REDUCED RETIREMENT ALLOWANCE FOR LIFE. I ALSO UNDERSTAND THAT MY NAMED BENEFICIARY WILL RECEIVE TWO-THIRDS OF MY RETIREMENT ALLOWANCE UPON MY DEATH FOR HIS OR HER LIFETIME, AND I UNDERSTAND SHOULD THE NAMED BENEFICIARY PRE-DECEASE ME, MY ALLOWANCE WILL REVERT TO OPTION A. AN ELIGIBLE BENEFICIARY MAY BE A SPOUSE, FORMER SPOUSE (unmarried at date of retirement), CHILD, FATHER, MOTHER, BROTHER, OR SISTER.

BENEFICIARY INFORMATION (MUST BE COMPLETED)

NAME OF BENEFICIARY:_____

DATE OF BIRTH:_____ SSN.:_____

RELATION TO MEMBER:_____GENDER:_____

PLEASE INCLUDE BIRTH CERTIFICATE OF BENEFICIARY AND MARRIAGE CERTIFICATE, IF SPOUSE

MEMBER INFORMATION

PRINT NAME:_____SSN.:_____

SIGNATURE:_____ DATE:_____

SIGNATURE OF WITNESS – THIS OPTION FORM MUST BE WITNESSED. IF MEMBER IS MARRIED, THE WITNESS MUST BE THE SPOUSE:

By witnessing this form, I acknowledge that I have read and understand the provisions of this Option:

PRINT NAME:_____

SIGNATURE:_____

ADDRESS:_____

THE COMMONWEALTH OF MASSACHUSETTS
STATE BOARD OF RETIREMENT
One Ashburton Place, Room 1219
Boston, MA 02108

RETIREE'S WITHHOLDING PREFERENCE CERTIFICATE
W-4P TAX FORM

NAME: _____ SOCIAL SECURITY #: _____

ADDRESS: _____

_____

PLEASE CHECK THE APPROPRIATE BOX:

☐ **1. I do not wish to have federal tax withheld from my benefit. I realize that I am liable for payment of federal income tax on the taxable portion of my pension and that I may be subject to pay penalties under the estimated tax payment rules if my payments of estimated tax and withholding are not adequate.**

☐ **2. The following exemptions are being claimed and I wish to have the Plan Administrator determine the amount, if any, of federal income tax to be withheld in accordance with the tax tables and exemptions claimed below.**

A) Marital Status:

Single _____ Married _____ Married, but withhold at higher single rate _____

B) Total exemption you wish to claim: _____

C) In addition to the above amount withhold an additional $_____ per month.

☐ **3. I wish to have a flat rate of $ _____ per month withheld.**

SIGNATURE OF RETIREE:_____ DATE: _____